collateral circulation and can considerably improve the peripheral blood supply in the presence of existing gangrene, and thus extend, peripherally, the limit of the amputation area. The method should not displace the present methods, as Moscowicz's method, but should amplify them.

The Diagnosis and Treatment of Gangrene of the Foot.—Moscowicz (*Zentralbl. f. Chir.*, 1913, xl, 507) calls attention to the fact that the objections to his method raised by Borchardt, can be overcome. He has often found that the application of the tourniquet is unnecessary. It suffices in most cases to elevate the affected limb for one or two minutes, in order to render it bloodless. That alone is a sign of disturbed circulation, since a mere elevation should not produce such a complete anemia. If the limb is then let down it slowly becomes red, but much more slowly than if the arteries are normal. In many cases he has allowed the limb to hang down vertically to favor the return of the blood, and even in this position one or several toes have remained pale a long time or persistently. By thus changing the position of the limb the same changes in circulation can be obtained as by Borchardt's alternating baths. He has also seen in one patient the pain of a deficient circulation moderated by the use of Klapp's suction apparatus, and the beginning gangrene probably retarded. He does not doubt that Bier's method of inducing passive hyperemia has a similar effect in quieting the pain and improving the nourishment. It is probable that the anastomosis of the femoral artery and vein will produce a similar effect, the more through the stasis due to the ligation of the vein than to the turning of the blood stream.

The Treatment of Beginning Gangrene.—Frank (*Zentralbl. f. Chir.*, 1913, xl, 508) confirms the value of Borchardt's method with the report of a striking case. A soldier suffered from frozen feet, which, on both sides, including the lower thirds of the legs, were edematous, cyanotic, cold, and tender on the dorsum of the feet. From the tender areas downward, they were without feeling. There was severe, almost unbearable pain in the parts of the limbs involved which had feeling. The saving of the toes and middle portions of the feet seemed hardly possible. It seemed that a Chopart amputation would be necessary. At best a Lisfranc, and at the worst an amputation in the upper third of the leg was in prospect. The alternating baths were tried and kept up for six months. The effect was striking. The right foot is now sound and useful. On the left side the great toe and a part of the plantar fascia were excised for gangrene. All the other tissues were preserved.

The Treatment of the Pyelotomy Wound.—Bastianelli (*Zentralbl. f. Chir.*, 1913, xl, 420) says that surgeons are now favoring pyelotomy for renal calculi as against nephrolithotomy, but that the special technique has not yet received much attention. He believes that if the proper indications are observed and the operation properly performed, the details of the suture are not particularly important. The wound in the pelvis heals without suture, if there is no obstruction to the outflow of the urine, the infection is not severe, or the wound is not too large or irregular. Yet it is not advised that the suture should be systematically avoided. The incision may be made directly through the fat and pelvic wall, and the closure made by catgut sutures which include both layers to the submucosa. This applies especially to cases in which the kidney cannot be delivered from the wound. In one case a large calculus was exposed through a pelvic incision. Because the stone could not be palpated easily, the pelvis was well freed from the surrounding fat. After extraction of the stone, the sutures used to close the pelvic opening cut through. The wound was not superficial and its closure was accomplished by a quadrilateral flap taken from the fibrous capsule of the kidney, from which the fat was removed. Mayo used the fatty capsule for a similar purpose. In cases with stones in the calyces, the pelvis should not be explored too much with the finger or forceps, but a radial incision should be made directly over the stone through the renal parenchyma. The wound can be closed with sutures, and these overlaid with a fatty flap with good results. In a mildly infected hydronephrosis, the cause of which was a stricture at the upper end of the ureter, the pelvis was widely opened, the stricture divided anteriorly, and posteriorly. The wound was then closed in a transverse direction with a single row of sutures, and covered with a broad, fatty flap. Primary union resulted. When, because of the depth of the wound and the shortness of the pedicle, the kidney cannot be delivered, the fat should not be freed from the pelvis, but the incision should be made directly on the stone and the wound afterward left unsutured. The surrounding fatty tissue applies itself over the wound and closes it.

The Etiology, Symptomatology, and Pathogenesis of Acute Intestinal Obstruction.—Polacco and Neumann (*Deutsch. Zeitschr. f. Chir.*, 1913, cxxii, 42), in an operation for an acute intestinal obstruction, found the jejunum, at about its middle, strangulated by a long, thin, fibrous band, which passed from one coil of intestine to another. In this central protion of the jejunum were a number of protuberances from the surface of the bowel, each about the size of a pea and rather firm in consistency. The strangulated portion of the jejunum was encircled by a ring formed by the fibrous band which seemed to be formed by the union end-to-end of two elongated and pedunculated protuberances, similar to those found on other portions of the bowel. After the division of the band, the serosa at the site of strangulation was seen to be smooth, and the distal coils of intestine immediately filled with gas. The numerous, peculiar protuberances which were most numerous in the direction of the appendix suggested that a previous appendicitis combined with a fibrous peritonitis may have been responsible for them. The appendix was found posteriorly, surrounded by fibrous adhesions which showed the same peculiar protuberances found on the intestine. The appendix was removed as well as some of the protuberances. The histological examination disclosed that the rounded ends of the protuberances were made up of a connective tissue, rich in nuclei, and had a similar connective tissue capsule. There was some necrosis, partial hyaline degeneration, and edematous infiltration. The pedicle possessed abundant young